SOONERCARE OUT-OF-STATE SERVICES RULE CHANGES

Beginning Sept. 1, 2019 the Oklahoma Health Care Authority (OHCA) will enact changes to the agency's out-of-state (OOS) services policies. These changes will continue to ensure members have access to quality care while controlling program costs. **They will not impact routine medical care for SoonerCare members.**

In 2019 the Oklahoma legislature passed HB 2341, which limited SoonerCare members' services to in-state providers when possible. These changes to OOS services will allow OHCA to maintain compliance with federal and state regulations.

These revisions clearly define coverage and reimbursement for services rendered by providers that are physically located outside of Oklahoma. The policy also outlines provider participation requirements and documentation requirements for OOS service requests.

WHAT SOONERCARE MEMBERS

Need to Know

- Members living near the Oklahoma state border who regularly see a SoonerCare-contracted provider across the border will see no changes, as long as the provider's office is within 50 miles of the member's address.

- Medical care needed due to an accident or medical emergency while a member is travelling in another state is still eligible for compensation once medical necessity is determined.

- Single-case agreements and contracts will not be allowed under the rule changes. SoonerCare members currently receiving OOS services through single-case agreements will be transitioned to regularly-contracted SoonerCare

providers that OHCA medical staff have determined can provide the same level of care at OHCA's regularly contracted rates.

- Self-referrals will no longer be permitted and members will be responsible for incurred medical costs if they do not receive the proper prior authorization for OOS services. Members who think they need out-of-state services should discuss the apparent need with their primary care provider.

WHAT SOONERCARE PROVIDERS

Need to Know

- Except for behavioral health emergencies and true medical emergencies, all required prior authorization documentation must be received by OHCA 10 days in advance of the day the OOS services are to be rendered.

- Requests for care will not be evaluated until all required documents are completed and submitted to OHCA. See below for a list of required prior authorization documents.

- Members may not be sent to non-contracted providers, facilities or doctors. **While the referring provider may suggest a destination for the member's treatment, the ultimate decision on destination will be made by the OHCA Chief Medical Officer or his/her designate and will be based on treatment consistent with recognized standards of care, cost effectiveness and contract status of providers.**

- Telephone requests for OOS services will only be approved in true emergencies and must be followed promptly with the submission of all required documentation.

- Referring providers should submit complete requests by fax to OHCA Population Care Management at 405-530-3217.

- For emergent telephone requests, please call Population Care Management at 877-252-6002.

DOCUMENTATION REQUIRED WITH

Prior Authorization Application

- Suggested destination for care with reasons for suggestion as appropriate.
- Documents determining medical necessity for the procedure, such as history of present illness, past medical and surgical history, physical exam, lab and imaging reports, progress notes and other relevant documents.
- A clear statement of the diagnosis and diagnostic condition or conditions for which the OOS service is being requested.
- A clear summary of related treatment prior to the OOS request.
- Summary of treatment plan for which OOS services are being requested.
- Listing of physicians and/or facilities to which the member has been referred for diagnosis and/or treatment.
- Physicians consulted in Oklahoma who have documented inability to diagnose or treat the member in-state.
- Documents that establish why the service cannot be provided in Oklahoma or the next closest facility to Oklahoma.

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